SIGNATURE CARD
FOR
MONTHLY INTERIM PAYMENT CLAIM
FOR FISCAL YEAR 1998/99
(Form ADP 7890)

County Certification: I CERTIFY the services listed on the automated ADP 7890 form, MONTHLY INTERIM PAYMENT CLAIM, have been personally provided to the patient by the provider or under his direction by another person eligible under the Medi-Cal Program to provide such services and such person(s) are designated on this form. The services were, to the best of the provider's knowledge, medically indicated and necessary to the health of the patient. The provider understands that payment of this claim will be from federal and/or state funds, and that any falsification, or concealment of a material fact, may be prosecuted under federal and/or state law. The provider agrees to keep for a minimum of three years from the date of service all records which are necessary to disclose fully the extent of services furnished to the patient. The provider agrees to furnish these records which are necessary to disclose fully the extent of services furnished to the patient. The provider agrees to furnish these records and any information regarding payments claimed for providing the services on request to the California Department of Alcohol and Drug Programs; California Department of Health Services; Medi-Cal Fraud Unit, California Department of Justice; Medi-Cal Audits Project, Office of State Controller; U.S. Department of Health and Human Services; or their duly authorized representatives. Medical care services are offered and provided without discrimination based on race, religion, color, national or ethnic origin, sex, age, or physical or mental disability.

Direct Contractor Certification: I CERTIFY under penalty of perjury that I am the official responsible for the administration of Drug Program services in and for said claimant; that I have not violated any of the provisions of Sections 1090 through 1096 of the Government Code; that the amount for which reimbursement is claimed herein is in accordance with Chapter 3, Division 5 of the Welfare and Institutions Code; and that to the best of my knowledge and belief, this claim is in all respects true, correct, and in accordance with the law.

County or Direct Contract Provider: _____ **Contract #:** _____

Printed Name

County or Direct Contractor Fiscal Representative:

_____ ( ) _____ _____

Printed Name Telephone Number Signature Date

County Alcohol/Drug Program Administrator or Direct Contract Administrator:

_____ _____

Printed Name Signature Date

County or Direct Contractor Auditor-Controller, Finance Officer, etc.:

_____ _____

Printed Name Title Signature Date

Executed at: _____**, California**

P:\PUB-DATA\POD\BULLETIN\98-56\MIPCSIGD.WPD: October 6, 1998